

Number 6. Winter 2001

QUARTERLY DIVISIONS

**Beyond computerised
prescribing**

**Two GPs share their
computer stories**

**Addiction medicine and
the busy GP**

Primary Care Partnerships

**An overview of IMIT,
divisions and SBOs**



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CONTRIBUTIONS

Divisions Quarterly is a journal produced by General Practice Divisions – Victoria to enable all Victorian divisions and their GP members to participate in discussion about the changes in general practice that divisions are funded to implement. Other people associated with the Divisions Program, including consumers, are also invited to contribute.

All articles submitted for inclusion in *Divisions Quarterly* are subjected to a review process by the editorial committee before they are published. The committee members might request that changes be made to an article before it is published. If possible, the edited copy of each article is sent to each contributor for approval before the journal is printed. The editorial committee cannot guarantee that all contributed articles will be published in the journal.

Articles that have been published in another journal will not usually be published in *Divisions Quarterly*.

Please e-mail your article in Word 97 or an earlier version, or in Rich Text Format, to the following address:

<b.newton@gpdv.com.au>

If you do not have e-mail, please send your article on disk in one of the previously mentioned formats. If you cannot do this, please post a typed copy to the address included on this page.

Feature articles

Feature articles are approximately 1500 to 2000 words long. Please adhere to this word limit. Ideally, in writing your article, you will meet as many of the following criteria as possible.

- Generate debate about the theme.
- Promote analysis of the issues.
- Inform other people about the issues in the Divisions Program.
- Promote and affirm divisions and their work.
- Contribute to setting the research agenda for the Divisions Program.
- Ensure that the article has statewide or national relevance.

The next issue

The next issue is scheduled for Spring 2001.

The theme will be based on issues arising from GPDV's second annual conference, held in March 2001, at which structural change in general practice and population health were addressed. We seek contributions on these themes as well as other articles of interest to the participants in the Divisions Program.

Deadline for contributions: 31 August 2001

LETTERS TO THE EDITOR

We seek letters from GPs and other people. Because one of the journal's purposes is to generate debate and discussion within the Program, the 'Letters to the Editor' section will be a significant feature of subsequent issues. Letters that are more than 300 words long might be edited to fit in with this word limit.

Please address your letters to:

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DISCLAIMERS

Publication of articles in this journal does not imply the endorsement of GPDV. All articles include the contributor's opinions and do not necessarily reflect the views of GPDV. We wish to promote debate and will therefore present many points of view in each issue.

Some articles in this issue contain references to specific brands and companies but are in no way an endorsement of these products.

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Editorial: The future of GP informatics

Frank Quinlan

When we invited Frank Quinlan to be guest editor for this issue, he was the national co-ordinator of the General Practice Computing Group (GPCG), and for two and a half years had been at the centre of developments in information management and information technology for general practice. In this editorial, he raises serious questions about whether the momentum of change in IM and IT in general practice can be maintained under what seems to be DH&AC's and the government's policy.



I am indeed fortunate to have the opportunity to reflect on the future of GP informatics at precisely the time I am moving on from being the national co-ordinator of the General Practice Computing Group (GPCG). I believe it is time to assess what GPCG has achieved over the past two and a half years as well as to ask what it might achieve over the next few years.

What is GP 'informatics'?

In recent announcements, it has been suggested that government policy is 'moving from information technology to information management'. As suggested in the articles by both Jennifer Fleck and Jane Cafarella, this distinction is without value. In Figure 1, which was essentially devised by Jennifer, the interrelationship that exists between the major elements of IM and IT is illustrated.

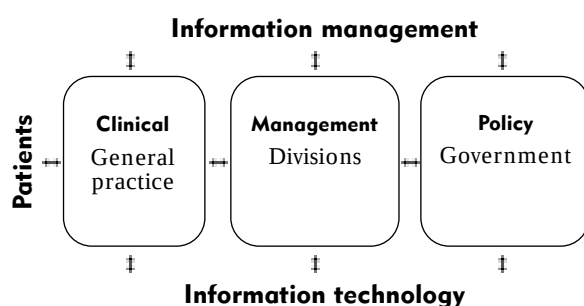


Figure 1: How information management and information technology are interrelated

GP 'informatics' is about systematically enabling GPs to improve their decision making through better use of information. There are many sources of information in general practice, some of which lend themselves to being electronically collected and manipulated and some of which do not. Informatics is partly about determining what the

most effective methods are for managing various types of information.

... GP 'informatics' is about systematically enabling GPs to improve their decision making through better use of information.

In the context of GP informatics, answers are demanded for the following questions that GPs must ask and continue to ask.

1. How much of the information needed is already collected as part of 'doing' general practice?
2. Can GPs better manage the information to help them improve patient outcomes and profitability?
3. Can they collect more or better information to make these improvements?
4. Can they collect or manage any information on behalf of other parties -- especially the government -- in a way that does not interfere with the business of being a GP?

What have we achieved at GPCG?

I will leave it to other people to comment directly on what we have achieved at GPCG. When I reflect on the broader issues associated with computer use in general practice, I believe it is fair to say that GPs have come a long way.

Most importantly, a partnership has been achieved in general practice. Over the past two and a half years, in an environment in which there has been a great deal of tension between general-practice organisations over a range of issues, the organisations have reached unprecedented agreement about what strategies they will adopt to implement informatics. We should not discount the power of this unity.

Strategic investment

The result of this unity of purpose has been GPCG's ability to invest strategically in a range of key projects, such as:

- the GP Coding Jury
- the GP Data Model
- Electronic Health Record Architecture
- software accreditation
- standards implementation, including patient discharge and referral.

We made all these investments as part of an approach to building up core pieces of the infrastructure that is necessary for supporting a range of computer uses such as the ones that Rob Ferguson and Danny Silver describe in their articles. Also, because of the investments, standardisation is promoted across the range of activities that GPs such as Rob and Danny already find useful, and GPs will be enabled to add value to their professional services by sharing and comparing their information.

Support and training

Finally, our IMIT support officers in divisions and SBOs have established an infrastructure for supporting and training GPs in IM and IT. Although most people would agree that in the first two years of this program all the answers have not been provided for general practice, it is clear that the program is well regarded by GPs. It has also been shown – if anyone doubted it – that enabling divisions to build their capacity to address IM and IT issues is the key to success.

. . . Most importantly, a partnership has been achieved in general practice.

Change among our target population

While we have been engaging in all this activity, we have seen much change among the GPs who are our program's target population. Some of these changes are described in much more detail in the article by Peter Schattner and Catherine Pleteshner. We have seen:

1. many more GPs using a computer to write prescriptions
2. more GPs using a computer to download pathology and radiology reports
3. consolidation in the general-practice software market, although the market remains immature and unpredictable

4. an increase in expectations, especially from government, about technology and improved outcomes

5. users becoming increasingly polarised, that is, widening of the knowledge gap between the GPs at the 'front of the pack' and those at the 'back of the pack'

Commonwealth initiatives

Over the past two years, the Commonwealth Government has introduced substantial initiatives, including:

- the Practice Incentives Program (PIP)
- Health Connect
- the Better Medication Management System
- Co-ordinated Care Trials II
- Enhanced Primary Care (EPC) items
- immunisation via ACIR online
- virtual amalgamation
- Public Key Infrastructure (PKI).

The government also addressed health-priority areas in the May Budget, including, for GPs:

- diabetes
- asthma
- cervical screening
- mental health
- Quality Use of Medicines (QUM).

As yet, it is unclear how the May Budget initiatives will affect GPs. Before the budget, we anticipated that the initiatives would be the focal point for co-ordination of activities to improve information management in general practice. We were told that we would draw from the various initiatives the specific funding to support the continued development of IMIT in divisions. Because of the

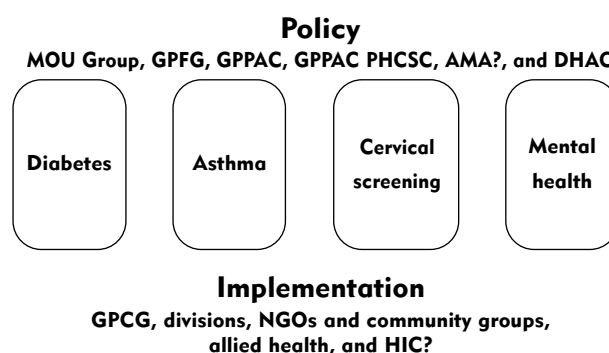


Figure 2: The May Budget

existing structures and the complete absence of detail in the budget initiatives, it is hard to see how we might do this.

'Silos' and relationships

What we do see in the budget is a range of initiatives through which a row of old-fashioned 'silos' – separate, isolated containers of funding seem to be created. A range of groups is to have some kind of as yet poorly defined role in determining how the policies for these initiatives are to be developed. The main focus seems to be on the MOU Group, but other groups include the General Practice Financing Group and the General Practice Partnerships Advisory Council. The changing relationship between the Minister for Health and the AMA might also have an impact on who participates in the discussions!

In turn, these general-practice groups will have to establish a relationship with the various national groups that are responsible for addressing the specific health priorities involved, such as diabetes and asthma, in order both to determine appropriate strategies and to plan how to implement the programs. The roles of divisions and SBOs, not to mention the GPCG itself, will have to be included in the relationships and planning so the programs and change can be delivered 'on the ground'.

Outcomes: yes; infrastructure: no

According to evidence to date, it is suggested that the 'silos' are likely to remain intact. Although the government seems to be keen to fund 'outcomes' in specific priority areas, minimal funding seems to be available for building the infrastructure that might be necessary to achieve these outcomes. For example, two years ago, when the GPCG began implementing the GP IMIT Strategy, we allocated two-thirds of the available \$15 million to providing support and education activities in divisions and SBOs. We now know that in December this year, the government will withdraw its funding for these activities. On the face of it, it is difficult to see how these activities will be supported into the future. One thing is certain: there will be a scaling back of activity.

The future for GP informatics

First, the bad news: progress towards real change is likely to remain slow and fragmented. The medical-software industry is likely to continue to contract and consolidate. Government programs are likely to remain 'silo' driven, and it will become increasingly difficult to co-ordinate the programs as their number increases. Efforts to harness

information technology in order to improve information management are likely to remain driven by government programs and commercial interests.

Now for the good news

GPs, like other technology users, use functionality that is of use to them and their patients, and will abandon functionality that is not directly useful. Two years ago, who would have thought that as many prescriptions would be generated by computers as we have seen over the past six months? Over the coming months, the full extent of the change will be documented in evaluations and research reports. In the meantime, real change will continue to be driven by the efforts of GPs working 'at the coalface'.

. . . real change will continue to be driven by the efforts of GPs working 'at the coalface'.

Sustainable change

Change to achieve better patient outcomes and greater efficiencies in delivering services will occur in sustainable forms only when GPs and their staff members begin to 'manage' the information they are already collecting in the course of running a general practice.

Many GPs are already using improved information technology to do this, and the government and divisions are well placed to help more of them do the same. This can occur without national databases or even divisional aggregations. It cannot occur without skilled and talented 'information managers' who are able to work with GPs and their staff in the practice setting to discover new ways of advancing general practice.

Divisions are the logical place – perhaps the only place – in which this 'intimate' intervention might occur. The challenge will be to extract the resources required in order to support these activities, for a sustained period of time, from the range of Commonwealth Government initiatives that are at present developing in isolation.

Until 29 June, Frank Quinlan worked in Canberra as national co-ordinator of the General Practice Computing Group. He is now working for the Canberra office of the AMA. His departure from the GPCG is a serious loss to the Divisions Program.

THE FUTURE OF THE GPCG – OR FINDING IT A HOME

This is the text of a letter circulated in June by the elected members of the Management Committee of the General Practice Computing Group, which is the peak body for general-practice computing.

The May 2001 Budget provided funding for the GPCG and its secretariat for another three years.

The historical background to the auspicing of the GPCG is important. The AMA took the running with the GPCG, initiating and establishing the secretariat in 1998 prior to funding being made available from the DHAC in 1999. Therefore the contract to auspice the GPCG Secretariat, signed by the AMA and DHAC, expires on 30 June 2001.

As far back as March, the GPCG Secretariat contacted DHAC in order to determine the ongoing contractual situation for the period after 30 June 2001. There was no response.

The GPCG Management Committee became aware at its April 2001 meeting that there were intentions to relocate the GPCG Secretariat elsewhere than in the AMA's Canberra offices, but no communications or documents at all were forthcoming from DHAC or from the Minister to confirm or to clarify this. Rumours abounded. By early June, the situation was still not any clearer, and the AMA was forced to give the Secretariat staff notice that their jobs would end on 30 June.

At a regular meeting of the GPCG Management Committee on 7 June 2001, a copy of a letter from Lynelle Briggs of DHAC, dated 6 June 2001 and addressed to Michael Kidd as Chairman, was tabled. In this letter, she advised the Chairman that she had decided to 'invite the Royal Australian College of General Practitioners (RACGP) to submit a proposal to auspice the GPCG for the next three years.' She went on to say, 'The decision to change the auspice arrangements for the GPCG has been made to capitalise on the RACGP's experience in setting standards for general practice, and developing training programs for GPs.' She added that '... the College has agreed to submit a proposal for the auspice arrangements to me by Tuesday, 12 June 2001. I expect to be able to forward a firm proposal to you by 19 June 2001.'

The GPCG Management Committee suspended the agenda in order to deal with the crisis at hand. In summary, the Management Committee felt that DHAC had breached the trust of its partners in GPCG, by failing to negotiate the further funding and operation of the GPCG in good time and in an open and transparent manner. Further, members

of the Committee felt that DHAC had been less than honourable in deciding to invite the RACGP to take over the 'auspicing' of the GPCG without consultation with the GPCG Management Committee. There was considerable discussion about whether the RACGP had been, or is, complicit in the breach of partnership trust by DHAC.

After several hours of discussion, a motion was passed 'That the GPCG Management Committee expresses its current lack of confidence in DHAC as a partner in GPCG in relation to the management of the auspicing and re-funding of the GPCG.' It was passed unanimously, with only three abstentions.

There were moves towards proposing a censure motion against the RACGP for its role in this, but this did not eventuate because there was not enough information to make a decision.

The GPCG has been credited by many as being the major reason for the quantum step forward taken by GP informatics in Australia during the past two years. Its success has been due, in large part, to its consisting of a partnership and trust between the RACGP, AMA, ADGP, RDAA, MSIA, consumers, DHAC and the HIC. This trust has been damaged and must be remedied.

Just as important to its success has been the diligence and commitment of the loyal and dedicated GPCG Secretariat staff. It is vital that continuity of employment of the Secretariat staff be given the highest immediate priority.

Finally, if GPCG is to continue functioning successfully, it must be administered in a totally open and transparent manner, with consultation among all the partners in GPCG.

In the mind of the Management Committee, the issue is not so much who should auspice the employment contract and accommodation of the Secretariat, but that the process of re-auspicing the GPCG Secretariat has been managed appallingly by DHAC. It appears that the DHAC does not regard the GPCG members and member organisations as equal partners in this venture to promote and progress general-practice IM and IT in Australia.

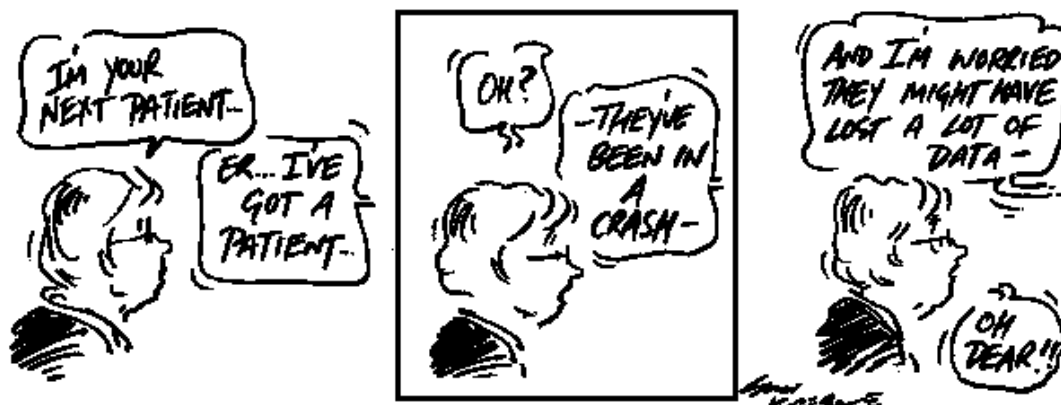
Since the last GPCG Management Committee, the DHAC has accepted the RACGP proposal regarding the auspicing of the GPCG. Intensive negotiations have been undertaken by the DHAC, GPCG and RACGP to resolve the issues with auspicing the GPCG Secretariat and staff, the composition of the GPCG Management Committee and the long-term future of the GPCG.

We will be working positively with all relevant stakeholders within the general-practice profession

to finalise the details of the auspicing arrangements and to ensure that the GPCG Workplan, as it evolves over time, achieves its aim to benefit the profession.

Signed by the elected members of the GPCG Management Committee:

Michael Kidd, Teng Liaw, Heather Leslie and Trevor Lord



The General Practice Computing Group

The General Practice Computing Group (GPCG) is the peak body for computing in general practice. It was established in 1997 by members of the profession, and since 1998 has been funded by the Commonwealth Department of Health and Aged Care. The group members focus on GP informatics by helping GPs use information management and technology for clinical and administrative purposes. They also develop both national linkages and open standards, in partnership with government, health consumers and the software industry. The GPCG Secretariat is responsible to a management committee, and administers a number of working groups and steering committees.

Membership of the group is open to GPs and their affiliates who are interested in or have expertise in general-practice computing. Affiliates include representatives of the medical-software industry, consumer organisations, DHAC and divisions' IT support staff. In March 2001, the group had more than 250 members, most of whom were GPs. In electing the GPCG Management Committee or dealing with matters to be decided by way of a vote, only GP members are eligible to vote.

The Management Committee members are listed as follows.

Elected members

Professor Michael Kidd (chair)
Dr Heather Leslie
Professor Teng Liaw
Dr Trevor Lord

Nominated members

Dr John Aloizos: GPPAC
Dr Peter Charlton: HIC
Mr Tony Firth: MSIA
Dr Oliver Frank: RACGP
Ms Louise Kamp: DHAC, GP Branch
Dr Peter MacIsaac: DHAC, GP Branch
Ms Debra O'Connor: Consumers Health Forum
Dr David Senior: RDAA
Dr Arn Sprogis: AMA
Dr Sue Whicker: RACGP
Dr Steve Wilson: ADGP

To find out more about the GPCG, go to the Web site: <<http://www.gpcg.org/>>.

GPs and computers: my journey so far

Rob Ferguson

Armed with stories, snapshots and a wish list, Rob Ferguson takes you on a tour of his life in Mordialloc as a computer-literate GP. He is not yet convinced that GPs will ever be able to take full advantage of the potential of IT.



During my 15 years as a general practitioner, I have seen a marked change in the way that clinical and business information is stored and dealt with in the health area. The change has been both facilitated and accelerated as a result of computer technology. However, I believe we still have a long way to go before we are at the stage of fully using and exploiting the technology, as well as *managing* the information we already have – or should have – about, and for, our patients, so both parties benefit. I believe we will probably never reach that stage.

To my mind, apart from the list of disincentives I set out later, the main barriers to what we have achieved and what we can achieve are bureaucracy, consumer and user expectations. and lack of vision.

The '80s: ledgers and cards

In the mid-1980s, when I joined my practice in Mordialloc, a south-eastern suburb of Melbourne, the GPs were using – and had been using for several years – a Xenix-based program for maintaining their patient accounts and reporting; a handwritten ledger for recording their office accounts; and alphabetically filed 8 by 5 inch cards for keeping their clinical notes, whereby they tucked the correspondence and results into clear-plastic sleeves. Maintenance of the practice's problem and medication lists depended on how enthusiastic the individual GPs were, and disease and procedure recalls were virtually non-existent.

The early '90s: A4 folders

In 1991, we changed over from using patient files on card to using A4-size folders, whereby we filed our results and correspondence sequentially, and more regularly maintained our problem, immunisation and medication lists on a separate, different-coloured page. It was about this time that the pap-smear register appeared, and we welcomed it.

The mid-'90s: downloading

In 1995, four of us took the plunge and set up a small network to run a popular clinical program.

Fortunately, in 1989, when we moved into purpose-built premises, we had the foresight to instal cable ducting throughout the building. In no time at all, we were prescribing and compiling histories electronically, and gradually using more of the program's add-on features. In 1996–97, we started downloading pathology and then radiology reports, and helped design the radiology-request form for the program we use.

1997: HCNet and a dedicated server

In 1997, as a result of my involvement with my local division of general practice and my interest in IT, Health Communication Network (HCN) contacted the division, and I became involved in the roll-out of HCNet. This concept was ahead of its time, but the idea was basically to have secure communication between the various health players and single-vendor computer solutions for practices. In late 1997, we spent rather a large amount of money and time changing our patient-accounts program and installing a dedicated server.

1999: a PC on every desk

Like most practices, we also spent more money again in 1999, as a result of the PIP focus on IT, and put PCs on all our doctors' desks. Over the past couple of years, our practitioners have been involved in the E-Ref project (see page 25: Kingston–Bayside PCP) to provide some local community and health services with electronic communication, as well as in the Asthma Integrated Care Program (ICP), in which we have been trialling use of software for clinical-decision support.

2001: a cyberspace odyssey

At present, we are running a network of five office computers and seven GP ones; a CD burner; 56 K modems; tape back-ups; zip drives; a scanner; and multiple printers. We make sure we do and automate as much of our backing up as possible out of hours. We use a multitude of software programs: Office Suite; internal messaging; MYOB; practice accounts; the White Pages Directory on

disk; the usual gamut of anti-viral and utility software; Medical Director; John Murtagh's Patient Education on disk; electronic Antibiotic Guidelines; and many patient-education articles, which are developed both in-house and externally. The extent to which our doctors use these programs varies, and ranges from simply writing prescriptions and downloading results to having some of our newer patients' full records on computer.

We have a primitive intranet in order to share this patient-education material and our common contact numbers. We produce most of our own stationery in-house, and do patient recalls monthly and Medicare claims daily. In our contact-address book, we have more than 2500 medical and allied health entries, and we have several dozen document templates for all types of clinical letters and forms that we use on a daily basis. Some of my patients have started e-mailing me to ask various questions they believe do not warrant a face-to-face consultation; however, I have tried to limit the e-mailing component as much as possible until the relevant reimbursement and medico-legal issues have been resolved.

In my opinion, scanning of documents is a mixed blessing because of the large workload endured by the staff members involved, and I am really looking forward to having specialists e-mail correspondence so we can simplify incorporating the reports in our electronic history record. Real-time Internet access is, of course, slow, because of dial-in phone modems, so at this stage it is not clinically all that useful. We can report in the usual variety of ways with reference to the practice's financial and item-number analysis by using the proprietary programs and exporting the information to a database program in order to review it more.

. . . I am giving my patients more information about their problems and better quality care as a result of using the computer . . .

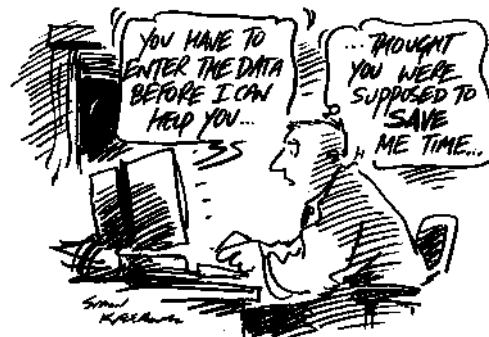
The barriers and disincentives

To date, what have been the barriers and disincentives for me and for our practice? I list them as follows.

- Time
- Money
- Apathy: colleagues', staff members', and at times mine
- Lack of peer and IT support
- Cultural and priority differences in the health

sector and a low perceived need for other players -- allied, hospital and specialist -- to communicate more efficiently with GPs

- Lack of industry standards for technology and transportability of data
- Privacy issues
- The difficulties of using the system, including:
 - steep and ongoing learning curves
 - poor GP and staff computer skills and awareness
 - technology changes
 - the need to repeatedly upgrade our hardware and software
 - dealing with an operating system, accounting and clinical software that are problematic
 - hardware failures
 - the relative lack of customisable featured clinical software
 - the fact that we have proprietary software for downloading pathology and radiology results and therefore have to endure multiple dial-ins
 - lack of fast, cheap and reliable Internet connection on a local basis



I am sure that everyone else who has clinically computerised will have encountered this warehouse full of barriers and disincentives, and more!

The incentives

What, on the other hand, have been the incentives? I list them as follows.

- Sometimes, being at the 'bleeding edge' of change can be a good 'buzz', although at other times it can be difficult and hard work.
- I believe I am giving my patients more information about their problems and better quality care as a result of using the computer on my desk and of using its clinical programs.

- Most of the rewards are intuitive and intangible – the ‘warm and fuzzy’ feeling I have whereby I feel I am doing more.
- There is all that checking of drug databases, interactions and allergies – although I realise that nothing is infallible.
- I have information to assist me in making my clinical decisions, as well as action prompts and recalls on the computer screen.
- It is very helpful to have addresses and phone books available and close at hand.
- It is very useful to have internal messaging.
- I and my staff members are certainly helped because we have less result filing to do on a daily basis. Specialists and hospital doctors often remark on the ‘detailed’ referrals I send them.

PIP and ICP funding

Financially, I do not know whether I can see more patients as a result of having IMIT, but I do feel I work more efficiently by having it – except when I am sorting out computer problems. Certainly, the funding from PIP and the ICP project have been useful in offsetting *some* of the dollar-cost disincentive. We are enjoying an advantage in starting to use the patient-disease database we have accumulated for searches, recalls and recording, because supposedly the aim, via PIP and other possible blended payments, is to improve disease management through use of disease registers for chronic conditions such as asthma and diabetes; however, external reporting about the outcomes, to funding authorities or divisions, also seems to be necessitated as a result.

‘When you wish upon a star’

Where would I like to be with reference to IMIT in my practice in the future? In my humble opinion, in the near future we will not have a truly paperless office; however, I want to aim to have one. Recalcitrant, Luddite organisations will always exist that require their proprietary paperwork to be filled out by hand.

. . . Recalcitrant, Luddite organisations will always exist that require their proprietary paperwork to be filled out by hand.

My wish list

- To have support for in-house networking, hardware and software – that is, for me not to be the one responsible for it
- To have fast, cheap and permanent Internet connection on all doctors’ workstations that

includes firewalls, mailboxes and seamless, encrypted e-mail communication with hospitals, specialists, pathology, radiology, allied health providers, pharmacists and community services, and ability to securely log in from home

- To have all these people enthusiastically and willingly communicating with me
- To have all doctors and staff members regularly undergoing computer-use up-skilling and being better able to analyse collected data at a practice level
- To have an interactive practice Web site that includes electronic appointments, practice information and patient-education material
- To not have a plethora of forms that have to be positioned in computer printers by hand
- To have ways of customising the clinical program more to my personal clinical practice
- To be able to more easily transfer data from one software program to another if I either wish or have to change vendors
- To have operating systems and databases that are more reliable and secure
- To have regular, planned upgrades of hardware and installation of new technology
- To have clear regulations for electronic-record security, privacy and ownership
- To have government realise that GPs’ IMIT use is not a matter of simply throwing a one-off fistful of dollars at GPs and divisions and expecting it all to happen, and to have government realise that recurrent capital, maintenance, training and time costs are involved
- To have IMIT as a core business of divisions and GPDV, including support, advocacy and – possibly – data warehousing and aggregation of de-identified clinical data for use in population-health targeting – for local ‘good and not evil’

And, of course, to make it all happen, I wish to have the *time* and the financial wherewithal – including e-medicine item numbers, whether the money comes from blended or – preferably – fee-for-service payments . . . Am I asking too much?

Rob Ferguson has been a full-time GP in Mordialloc for 15 years. He has been involved with Central Bayside Division’s board since its inception, and spent three years as its chair. He is especially passionate about expounding the benefits of IMIT to his fellow GPs and whoever else might listen.

Beyond computerised prescribing: what's next?

Peter Schattner and Catherine Pleteshner

Prescribing is understandably the main task for which GPs are using their desktop computer. Divisions now have to develop new strategies for advancing GPs further along the road towards managing information electronically.

Electronic prescribing was the logical starting point for the first phase of the Commonwealth Government's incentives program for getting GPs to use computers in clinical practice. Prescribing is a key element of GPs' payment within the IT component of the Practice Incentives Program (PIP). Prescribing by using a computer was also the main thrust of divisions' early support role in information management and information technology (IMIT), along with advising GPs about how to get the 'boxes and cables' on to the consulting desk. Recently, Monash Division surveyed its GP members' computer use in order to assess how successful this first phase of the computerisation process has been, and especially to determine how much GPs have moved beyond electronic prescribing.

The survey methods

Within its official postcode boundaries, Monash Division has 118 GPs and 65 practices. In late 2000, the division's IMIT officer, Catherine Pleteshner, phoned all 65 practices over a four-week period. She asked that the GPs in each practice nominate a representative -- either a principal or an associate -- who had a good grasp of the practice's IMIT uptake. She then invited each representative to be interviewed face to face, or, if that was not convenient, to be interviewed by phone.

In the structured interviews, the researchers addressed two broad areas of inquiry: the GPs' use of computers for managing the practice or completing administrative tasks -- an area we are not reporting about in this article -- and their use of computers for completing clinical tasks.

Catherine based the interview schedules on posing 'closed' questions in which she covered a range of clinical functions for which the GPs might use a computer. If the representative did not know the computer-use details for all the practice's GPs -- partners, associates and assistants -- the researcher gave the paper-based questionnaire to the individual GPs to complete and return to Catherine. This procedure was usually followed for

any practice that had more than two doctors. When all the questionnaires had been completed, the researchers analysed the data using basic, descriptive statistics.

The results

Of the division's 65 practices, 63 representatives participated in the survey. Most of the interviews were conducted face to face, and only six were conducted by phone. When the survey was being undertaken, computers were being used to either manage the practice or complete clinical tasks in 52, or 80 per cent, of the 65 practices.

Electronic prescribing

Seventy-three, or 62 per cent, of the 118 GPs were using their computer to prescribe, and almost all of them were using the one software program to do so. In Table 1 below, we show electronic prescribing, by the GPs' age group.

Table 1: Electronic prescribing, by the 118 respondents' age group

<i>The respondent's age</i>	<i>The number who electronically prescribe</i>	
	<i>Do</i>	<i>Don't</i>
Younger than 40	21	6
Between 40 and 65	51	35
65 and older	1	4
Total:	73	45

Computer use

In Table 2 on page 12, we list the main uses to which GPs put their computer in their practice. From the table, it is clear that most of them did not use the computer for any purpose other than to prescribe. In this group of GPs, the second-most common use of the computer was to print information about patient education. The next-most important purpose was to download

pathology and radiology results, although we do not know whether GPs have completely adopted this function in preference to using paper-based results.

Table 2: 117 respondents' use of their computer in their practice

<i>Computer use</i>	<i>% using</i>	<i>% not using</i>
Printing information about patient education	45	55
Downloading pathology and radiology results	41	59
Wordprocessing, excluding 'letter writer' in prescribing programs	37	63
Recalling patients	35	65
Writing patient-referral letters, using 'letter writer'	32	68
E-mailing	32	68
Recording notes about patients' clinical progress	26	74
Receiving hospital-discharge information about patients, excluding faxes	3	97

Internet use

The researchers also inquired about the respondents' use of the Internet either at their practice or after hours: most of the GPs did not use the 'Net at work, and relatively few of them used specific search tools in order to find clinical information. Of the ones who used the 'Net, most did so for non-medical purposes, as we indicate in Table 3, opposite.

Discussion

In our metropolitan division, a substantial number of GPs are still not using a computer to prescribe: 45, or 38 per cent, of the 118 survey respondents. This figure is lower than that indicated in the data for the Practice Incentives Program (PIP). According to that data, in November 2000, 42 practices in Monash Division were registered for the program, 71 per cent of them were involved in electronic prescribing, and 83 per cent of them were using electronic-data transmission.

However, the division's survey is likely to be the more accurate gauge, because PIP applies to only the practices in which the GPs voluntarily choose to register for the program. Importantly, we have revealed that most GPs do not use their computer for much more than prescribing, although we did not inquire about the respondents' use of the many 'clinical tools' that accompany the prescribing software. We also do not know to what extent GPs electronically view downloaded pathology and

Table 3: The respondents' Internet use either at the practice or at home*

<i>Internet use</i>	<i>Number</i>	<i>% using</i>	<i>% not using</i>
At work	116	27	73
During consultations	115	5	95
At the practice as a source of medical information	117	25	75
Browsing either at the practice or at home	103	65	35
Receiving electronic journals	103	21	79
Browsing in general: finding medical information	103	62	38
Searching for specific clinical information using 'evidence' databases such as Medline and Cochrane	103	46	54
Finding other, non-medical information	102	70	30

*Unless otherwise stated, assume that the respondents used the Internet in their practice, at home or both.

radiology results, given that most, if not all, GPs are also receiving paper-based reports.

Where to next?

As a result of the survey findings, we have to ask the following two questions about where GPs and computers are headed.

- What are the priorities for IMIT uptake, that is, for the transition from *learning how* to use a computer to *developing skills* in prescribing electronically, and to then *understanding how* to use a computer in order to 'manage information', for example use patient databases?
- How will GPs overcome the evident barriers to managing clinical data and making better use of the Internet, and what type of support will divisions be required to provide?

Computing: the clinical impacts

According to a recently published systematic review of the research being undertaken into the clinical benefits that ensue from computer use, surprisingly few of the benefits could be considered to be 'proven', although just because there is a lack of *demonstrated* benefit, it does not necessarily follow that there is no benefit. In general practice, tools such as the Internet could be placed in this

‘Useful’ category but be of unproven benefit. In Table 4 below, we list the clinical impacts of computing in general practice that are referred to in the systematic review.

Table 4: The clinical impacts of computing in general practice, as referred to in the systematic review of the impact of primary-care computing*

<i>Clinical-task area</i>	<i>Impact</i>
Maintaining immunisation rates	Improved – via having a reminder system
Promoting preventive activities	Improved – via either reminding the patient or prompting the doctor during the consultation
Managing diseases	Better management of chronic diseases, especially diabetes – via electronic protocols Possibly better control of blood pressure
Prescribing	A greater amount of generic prescribing Time saved
Satisfying patients	Unaffected by computer use during the consultation

*E. Mitchell and F. Sullivan, ‘A Descriptive Feast but an Evaluative Famine: Systematic Review of Published Papers on Primary Care Computing during 1980–97’, *British Medical Journal*, 2001, 322: 279–82.

Prescribing, and all the rest

When you read Table 4, you might agree that each clinical-task area can be categorised into one of the following subgroups.

- Prescribing, which involves responding to an immediate need during the consultation
- Maintaining immunisation rates, promoting preventive activities and managing diseases, in all of which the GP is required to implement some type of system for managing the practice’s databases. For example, GPs have to have more than computer skills if they are to provide recalls for their patients who meet specific criteria. GPs have to consider how the system will work in their practice, and which staff members will be involved in using it. A recall system in which no one enters the patients’ medical-history items in the electronic record will be very incomplete. It is not surprising that this group of three tasks lags behind prescribing

The hurdles

This survey was limited in that the researchers did not record in detail which aspects of the prescribing programs the respondents were using. However, it seems a gap exists between GPs’ taking up of electronic prescribing and their use of computers for other clinical purposes. The reasons why GPs have not adopted computers for other clinical purposes might partly be related to the fact that the existing software is inadequate for the purposes, although their apparent lack of interest is more likely due to a series of hurdles they face at both individual-GP level and practice level. These hurdles might include the extra time required in order to ‘manage information’, for example to develop and use a disease register or a computerised reminder system.

Moving beyond prescribing

It is therefore important that divisions – and other professional, government and industry bodies – continue to help GPs develop the skills and systems whereby they will be able to move beyond electronic prescribing. This is no easy task, because GPs seem to be reluctant to adopt new practices when the old ones have served them well for so long. However, opportunities exist for divisions to ‘tie in’ computing with GPs’ other needs. For example, GPs who wish to identify patients who are 75 and older in order to offer them a health assessment might be receptive to learning about the broader IM benefits that ensue from using a computer.

Divisions will therefore have to devise a series of strategies through which they support change in general-practice computing by linking it with the clinical tasks that GPs undertake, such as prevention, screening and managing chronic diseases. Much remains to be done.

Peter Schattner is an associate professor with Monash University’s Department of General Practice and is Monash Division’s IMIT consultant. Catherine Pleteshner is Monash Division’s IMIT officer.

Rural bits 'n' bytes

Danny Silver

Rural GP Danny Silver describes how information technology has been incorporated in his daily clinical practice. He reveals some specific ways in which IT is affected by the geographic isolation that characterises life as a rural GP, and provides some advice for his country colleagues who are considering using a computer in their practice.



It seems rural general practice is 'flavour of the month'. In an attempt to address the issues behind Australia's uneven distribution of medical services, governments have been closely studying many of the characteristics that are specific to rural general practice, such as workload, spectrum of clinical medicine and demographics, and have been comparing them with the characteristics of metropolitan practice. Computers are appearing on more and more doctors' desks, so it is timely to explore whether rural practices are also being confronted with some issues or idiosyncracies that are specifically related to information management.

Who am I?

I have been a general practitioner in Castlemaine, a country town in central Victoria, for more than 20 years, and have relied on electronic medical records as my main clinical *aide memoire* on a daily basis for eight years. I believe that because I have this many years of experience, I am adequately qualified to describe some of the issues I have encountered and to provide some ideas for you to consider.

Plugging in and plodding on

At present, our practice has four doctors, including an RACGP registrar. We first became computerised in 1993, when we were awarded one of the Commonwealth Government's first few Demonstration Practice Grants for funding a project that would involve information management (IM). The intention of our project was to explore how management of patients in our hospital's emergency department was influenced by the extent to which participating GPs in two group practices located in Castlemaine accessed computerised medical records after hours.

Unfortunately, because some of the doctors withdrew their support for the project soon after it began – much to my dismay – nothing was destined to be revealed except the fact that enthusiasm for computers is neither universal nor contagious! Nevertheless, as a result of the government's benevolent grant, two of the group practices in Castlemaine were given funds for purchasing the computers, peripherals, software and training required in order to undertake the project. And ever since then, the four GPs in our practice have been exclusively using our computers and electronic medical records for storing clinical information.

. . . enthusiasm for computers is neither universal nor contagious!

We have long since given away, and replaced at our own cost, all the computers we originally paid for through the one-off grant – and I believe they are continuing to work well for their non-demanding owners. Because Macs are much more reliable than most PCs and much easier for computer-illiterate users to deal with, over the past eight years I have been able to do all the hardware and software installations, upgrades and maintenance in our clinic without having to resort to getting expensive help from IT professionals.

PIPPed at the post

Since 1991, when the Commonwealth Government made the original round of Demonstration Practice Grants available, the government has offered once-only funding to purchase computers for all GPs through the Practice Incentives Program. I found it difficult to understand the program's logic, whereby the government offered the most money to the GPs who had already invested heaps of money to incorporate computers in their practice and were using them to write prescriptions and access the Internet, and offered the least money to the GPs who had not taken the first steps towards computerising their practice.

How our GPs use computers to manage information

We have integrated all our appointments and accounts with our medical-records software, and both our office staff members and our doctors can either create or change appointments and generate accounts and receipts. For the past eight years, all four of us have been:

- typing all our clinical notes either during or immediately after our consultations
- providing our patients with their referral to a specialist or a paramedical professional, as well as with other types of letter, during our consultations
- providing computer-generated prescriptions and request slips for pathology and radiology ever since it became legal to provide them electronically.

For the past year, we have been downloading our pathology reports from our local hospital's pathology provider; however, our radiology provider is struggling with its software company to develop similar functionality. Although at present our hospital-discharge summaries are coming back to us on a floppy disk, we are planning to

implement secure e-mail delivery. However, when the e-mail concept expands to include all inter-doctor patient-related communications, the method might well prove to be too clumsy for providing security because of the issues of encryption and public versus private keys.

Our digital camera

We have a fantastic SLR digital camera for producing macro-photography of skin lesions, rashes and obvious deformities. It has proved to be invaluable for us in preparing our clinical records and in teaching undergraduate medical students, RACGP registrars and our GP colleagues. We store all the photos – more than 1000 at present – on our server as well as on my laptop, and we can access them from within our patients' medical records by simply double clicking to open the selected high-resolution photo within two to three seconds! Patients love being able to see these photos on the computer screen, especially the ones of lesions they have never seen properly!

. . . Patients love being able to see these photos on the computer screen, especially the ones of lesions they have never seen properly!

The hard-copy blues

Although we have the necessary equipment and software, as yet we have not started to routinely scan specialists' incoming hard-copy correspondence in order to incorporate it in our records. Unfortunately, this remains a very labour-intensive computing activity, so we are forced to store the information in hard-copy form. We therefore do not yet have an entirely paperless medical-records system; recently, though, several specialists have agreed to e-mail their correspondence to us and to send the hard copy at the same time – old habits die hard!

The Genie in the bottle

After searching our souls and investigating alternative software packages, we finally abandoned the medical-records software we had been using for the first seven years we were in practice together. In early 2000, we purchased a more capable and modern program, called Genie. The two programs had major incompatibilities, so we experienced a bit of a culture shock. The changeover proved to be quite a workload, because we had to copy and paste between the programs all our clinical notes, one by one, for each and every patient record. By early 2000, we had almost 10,000 patients on our system, so you will appreciate the magnitude of the changeover. However, the changeover is now just

about complete, and we only occasionally have to 'boot up' the old software.

Useful templates

Our new software can be easily used to generate templates, whereby general practitioners can create all types of forms for recording data, and can print them out as required. For example, you can re-create the double-sided RACGP obstetric-record sheet as a template, and enjoy the added facility whereby the software automatically incorporates data, such as about the patient's past history, current problems and allergies, that is already stored within your patient notes. Three other useful templates we use are a pre-anaesthetic assessment form, a warfarin-dosage/INR record form and a prednisolone-reducing schedule.

This is clearly a shameless plug for what we consider to be fabulous software. And for all you PC users, Genie is now 'cross-platform' and not just a Mac program -- check it out at www.geniesolutions.com.au . . . Don't worry -- I'm not on commission, just a happy user!



Now for some answers to your specific questions about rural issues.

Do patients and staff members accept computerisation?

Rural dwellers are often more conservative than city people, so rural GPs can have some difficulties when they introduce computers in their practice. However, this issue is gradually becoming irrelevant, as more and more rural dwellers purchase their own computer and expect their doctor to be up to date and using the latest technology. Back in 1993, when we first started electronically recording our notes during consultations, computers were much more of a novelty; however, our patients quickly grew to accept them as being a wonderful tool when they saw their referral letters being done almost instantly in front of them rather than 'some time



over the next couple of weeks'. Also, when it finally became legal to generate prescriptions electronically, our patients were delighted that they could finally read them!

At first, our staff members were tentative about using computers; however, they eventually became very tolerant of my enthusiasm and very quickly learnt how to use the system. Now they depend on the computers and are the first ones to complain if something is not working perfectly!

. . . our patients quickly grew to accept them as being a wonderful tool when they saw their referral letters being done almost instantly in front of them . . .

How do you manage all that information management?

Rural areas have fewer doctors -- which is why so much fuss is being made nowadays about rural general practice -- and as a consequence, there never seems to be enough time to do all the work. Rural GPs can be overwhelmed if their workload increases because they have to learn how to use a computer and type quickly -- it is a 'no-brainer' that touch typing is an invaluable skill, and it is well worth the initial effort of spending 15 to 20 minutes a day using your computer's typing tutor. As is the case with any skill, touch typing improves if the learner practises -- and your patients will be very impressed if you can type quickly.

GPs can also become overwhelmed if they suddenly become responsible for managing the information management -- doing back-ups, upgrading, completing regular maintenance tasks, troubleshooting and so on; therefore, it definitely helps to have someone who is enthusiastic and interested in the technology take charge of the practice's IT. Of course, metropolitan doctors can also be extremely busy, and their time-management issues can be just as critical as rural GPs'.

What costs are involved in IT?

Computers cost money and time! Most things cost more in rural areas, and the further away you live from the 'big smoke', the more expensive it is to buy things or freight them up -- or freight them back, if they have to be repaired. If you choose to buy your computer hardware locally -- in your own town or your closest regional centre -- you are bound to have fewer options, and because competition is reduced, prices are usually higher than they are in city outlets.

How reliable is the power supply?

In rural communities, the power supply is often less reliable and there are more fluctuations in voltage – ‘spikes’ and ‘brown-outs’ – whereby computers can be damaged and the data they contain can be made irretrievable. For this reason it is absolutely essential that for each computer in your network, you have a back-up power supply that has in-built ‘power conditioning’, for smoothing out or limiting voltage fluctuations. We had a single industrial unit providing all our computers with power via an isolated circuit. However, when the unit broke down or its batteries had to be replaced, we decided to purchase smaller UPS – uninterruptible power supply – units for each of our desktop machines.

Three of our doctors use a laptop, which of course has batteries that are capable of supplying three to four hours’ continuous use, and therefore does not require back-up power supplies. Also, it is portable: mine is my work computer, my home computer, my house-call computer and my hospital computer! Its LCD screen gives off no potentially dangerous radiation, and the entire computer requires very little power to run – so you now have at least three good reasons for buying a laptop rather than a desktop computer!

Back me up on this one

In the rural setting, backing up your precious clinical and accounting data is more than important – it is mandatory! As the saying goes, ‘There are only two types of computer user: those who have already lost data and those who *will* lose it!’ In our practice, we have various back-up strategies, including daily backing up from our server to another computer on the network, and writing all the data in the medical-records database – including appointments, clinical notes, pathology reports and accounting data, as well as more than 1000 digital photos – to CD-ROM twice a week. Using a fast CD-ROM writer, this takes only five to six minutes! Unlike re-writeable CDs, the CD-ROM writer is also ideal for medico-legal purposes. For house calls and hospital visits, I also keep a back-up of our medical-records database on my laptop. Anything I add to the database I can later incorporate in the database back at the surgery by simply clicking a button, so the records at the surgery can be kept complete.

. . . ‘There are only two types of computer user: those who have already lost data and those who *will* lose it!’

How available are training and on-site support?

If you are a computer user who has no expertise in recognising and solving software and/or hardware problems, it is essential you have good technical support. The more a clinic relies on computers to manage its information, the more disastrous it is to have ‘downtime’. For this reason, it is vital you have reliable hardware and software, appropriate contracts for on-site support, and guaranteed response time to ensure that breakdowns do not last too long.

A Mac is a beautiful thing

We chose to buy Macs for our practice mainly because they had a well-deserved reputation of being reliable and easy to use, especially for the technically inept! In my experience they have certainly lived up to this reputation, and because we have had no expensive IT-support fees to pay, we believe that in the long term, Macs are the cheapest computers to own!

Cheapest doesn’t necessarily equal best

Unfortunately, many computer novices (which most doctors of my generation are) purchase on the basis of which system is the most affordable at the outset, and do not research what the ongoing costs are likely to be. They can then find that the economising involved in choosing the cheapest system has been cancelled out due to the fact that they have to deal with expensive and frustrating breakdowns or that they frequently have to call out the expensive technical-guru support team to fix some software glitch.

How available are the Internet and telecommunications?

The Internet is slowly reaching the Australian outback. However, in remote areas, the costs associated with getting connected to it are sometimes exorbitant because of the STD costs involved in connecting to the closest Internet Service Provider (ISP), which might be literally hundreds of kilometres away. Broadband services are non-existent out there, although at the time of writing, Telstra was experimenting with ASDL; unfortunately, though, this service is good for only a few kilometres from the closest phone exchange. For remote communities, then, satellite services will probably be the only solution for some time. The upshot is that upload speeds will remain relatively slow and the need for STD charges will persist, because satellite users still have to dial up their nearest ISP to obtain their upload links to the satellite ground station.

It is also quite common for rural Internet users to endure slower download speeds when they are using ordinary dial-up modem connections, because rural phone lines are poorly maintained. As more and more clinical information and services become available online, these disadvantages that rural GPs face will become increasingly frustrating.

What about branch practices and connecting practices?

Many rural practices maintain smaller branch practices in nearby towns that are too small to justify location of a full-time GP. Clearly, these branch practices have to have access to patient records; however, the central practice also has to maintain records in case patients from the smaller outlying communities present to the central practice. Paper-based records such as the RACGP record have to be carted back and forth between the central and branch practices, whereas if the medical-records system is electronic, the GPs can instantly access their patients' clinical records over either a phone line or a microwave link (line of sight; also known as expensive!) between the practices.

ISDN

Dedicated high-speed phone links – ISDN – are also expensive, but they have the benefits of being much more secure and having faster rates for data transfer. However, it is often difficult to justify the initial set-up costs for ISDN telecommunications equipment and the ongoing costs involved in maintaining it. Also, no funding is available to support rural GPs who seek to provide the more remote outlying communities with high-quality medical services by implementing this technology.

How do you manage hospital and clinic communications?

In many rural communities, the GPs provide the local hospital with most, if not all, of its medical services. They also often provide procedural services, including surgery, anaesthetics and obstetrics, as well as after-hours emergency cover. It is evident, then, that they frequently look after their own patients as well as the patients of their colleagues in group and nearby practices. Obviously, it is easier to provide good-quality medical care if the treating doctor has all the relevant information about an unfamiliar patient's medical background. However, all too often, patients, and even their carers, are not able to provide all the relevant details when they attend a hospital's emergency department.

The 'need to know'

One way to minimise delays and management errors or unnecessary duplication of investigations is to provide doctors who have a 'need to know' with secure online access to electronic medical records. In the rural setting, in which small numbers of participating general practices and GPs service rural hospitals, it is both affordable and now possible to set up systems to facilitate this access. Although in 1993 my efforts to examine this concept were undermined by way of giving inadequate attention to the all-important human factors associated with introducing computers in clinical practice, it is likely that this concept will eventually become accepted practice.

Because the medical profession is justifiably paranoid about unauthorised disclosure of confidential clinical information, the future will eventually be characterised by adequate security protocols and systems, including encryption and isolated telecommunications links.

... when they have a computer and good clinical software, they can better create and maintain their clinical notes to the highest standard, promote long-term benefits for their patients' care and enjoy medico-legal protection.

In summary

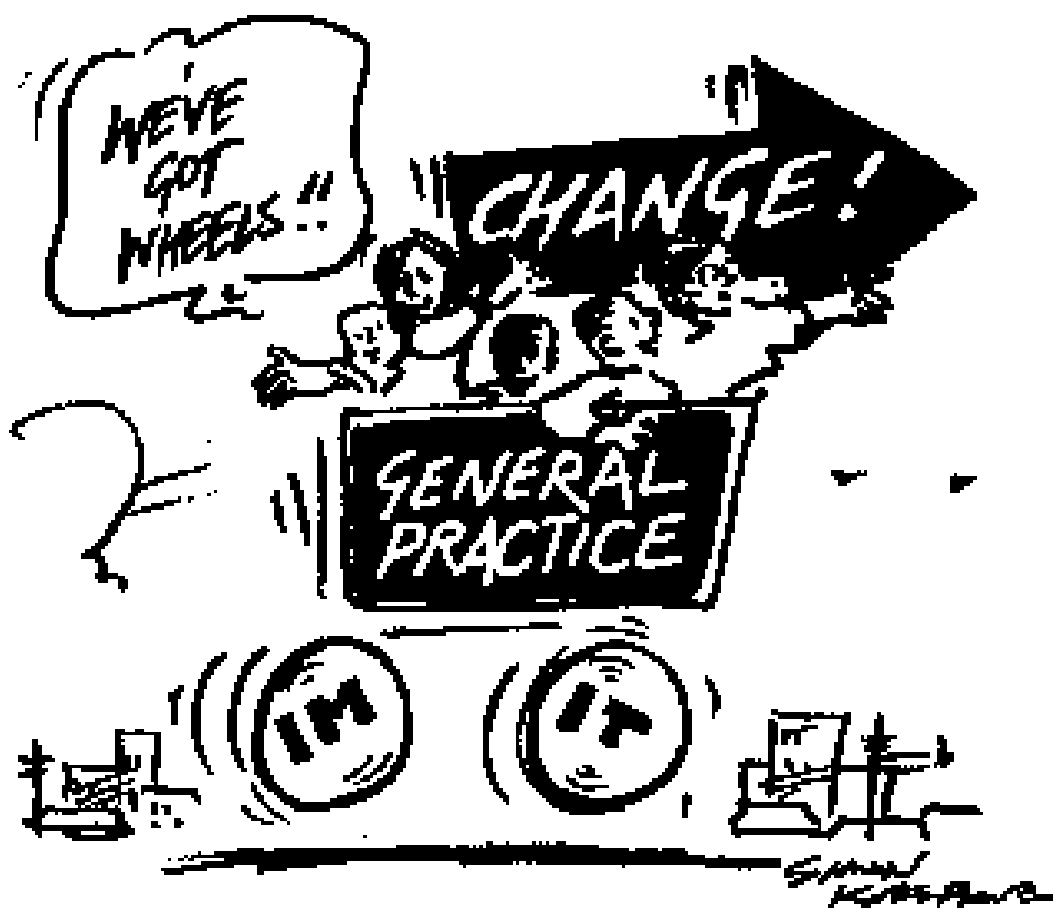
It is clear that rural GPs have to consider some added location-specific obstacles when they are planning to use a computer to manage their clinical and financial information. They can overcome some of these obstacles if they spend more money or require government to spend more money! However, they can and should overcome all the obstacles, because when they have a computer and good clinical software, they can better create and maintain their clinical notes to the highest standard, promote long-term benefits for their patients' care and enjoy medico-legal protection.

Danny Silver has worked as a GP in Castlemaine for 21 years and is wildly enthusiastic about most things, especially playing music, fiddling with computers and eating Charmaine's ice cream.

IMIT, divisions and SBOs: an overview

Jennifer Fleck

As an insider, Jennifer Fleck discusses divisions' role in developing IMIT in general practice over the past three years. She has found that GPs are confused about the concept of making the transition from IT to IM, and that there is a need for them to have basic training and support if they are to make best use of the technology for information management.



For the past three years, divisions of general practice have been 'drip fed' funding in order to help general practitioners computerise. Judging by the increase in the number of computers now gracing GPs' desks, the program has been an undeniable success. However, the downside is that because the funding allocated to divisions for IMIT has been short term and staggered, one of the fundamentals of the Outcomes Based Funding Program – encouragement of divisions and SBOs to move away from the concept of project-based, short-term business – has been denied.

Deadline: December

What, then, does the future hold? GPs are on the brink of realising the main benefits of having more information technology and therefore improving

how they manage information. However, specific funding for conducting IMIT programs in divisions and SBOs is set to end or be reduced from December this year.

... specific funding for conducting IMIT programs in divisions and SBOs is set to end or be reduced from December this year.

'Transition' equals 'confusion'

In general practice, neither information management nor information technology is a new concept. Through organisations such as the Australian Medical Association, the Royal Australian College of General Practitioners and, more recently, the General Practice Computing

Group, medical professionals have been recognising and promoting the benefits of both. They have also been acknowledging that an intrinsic relationship exists between the two.

However, the participants in recent discussions about IMIT's future in general practice have been confused whenever the 'transition from information technology to information management' has been referred to. It is clear that IT does not exist without IM as one of its purposes, and information management will be impossible without the tools provided by way of IT. In general practice, in which both the quantities and the types of information to be managed are increasing, it is becoming more and more difficult to manage the information effectively without having information technology as an aid. When the term 'transition from IT to IM' is used, it is implied that in the future, divisions will not support GPs in either computerising or developing their computer skills: they will have only an information-management function. Rather than accept this implication, divisions have to consider information management's future as an additional and complementary function that has to be incorporated in the existing information-technology support structure with which they provide their members.

... IT does not exist without IM as one of its purposes, and information management will be impossible without the tools provided by IT.

Required: time and training

Information management exists in and is an inevitable part of the computerisation process. Before massive IM programs are developed and implemented in divisions, the question that has to be asked is: *In general practice, are the existing IT systems, infrastructure and knowledge sufficiently robust to support this development?*

No doubt, individual GPs exist who already have a sophisticated IT system and use it extensively in their practice in the process of managing information. However, this is not the case across the whole profession, and all GPs are not at the same level of implementation. Considering the small amount of time that most divisions have had to develop their GP members' IT skills, this is a reasonable and acceptable situation. DHAC must accept that time and training are required if computers are to be effectively introduced in a workplace such as a general practice: a computer might be placed on a GP's desk, but that GP will not automatically know how to use it.

... time and training are required if computers are to be effectively introduced ...

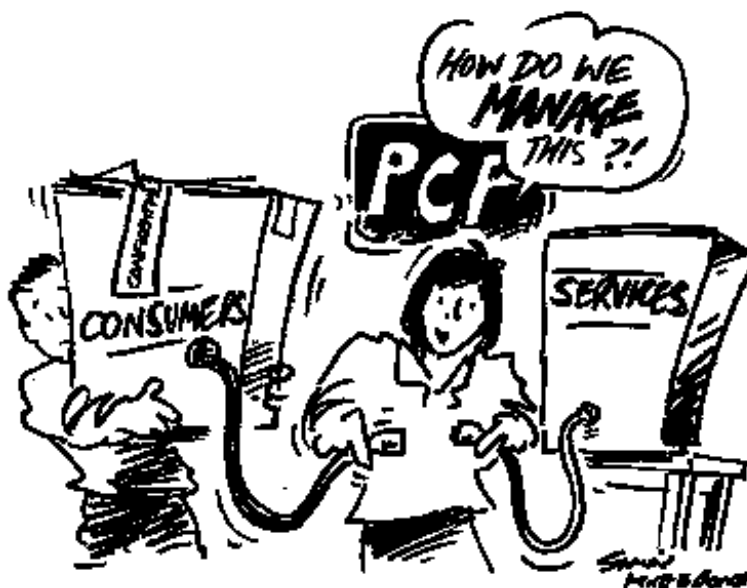
What is perhaps the most confounding factor in the equation is not knowing what, if any, funding will be available for IMIT programs after December 2001. Each time the funding is in doubt, divisions and SBOs suffer a greater cost in that they lose more staff members, and with them, skills and corporate knowledge. The real disaster is that they are losing these skills and knowledge just when they should be strengthening their position as IMIT advocates and educators to reinforce the successes in general-practice IMIT.

Jennifer Fleck has been IMIT advisor at the Queensland SBO, Queensland Divisions of General Practice, since July 1999. Before that, she worked at Bayside Division in Brisbane, and then at Brisbane Southside Central. From November 2000 to May 2001, she was seconded to the national divisions' organisation, Australian Divisions of General Practice, to review the future role and function of IMIT officers in divisions and SBOs.

Primary Care Partnerships: making them work

Jane Cafarella

IMIT will have a big role in making Primary Care Partnerships (PCPs) work. However, if IMIT is to be effective, the partners will have to work out the best ways to share the information about their patients before they go ahead and buy the boxes and cables for storing and transmitting the information.



When you walk into the waiting room tomorrow and summon your next patient, will you think of him or her as being *your* patient or *our* patient? If you answered 'our patient', congratulate yourself: you have grasped the basic concept of Primary Care Partnerships (PCPs). In the 'ideal world' of Primary Care Partnerships (PCP), GPs and other primary-care givers in the same local-government area will work together to co-ordinate and integrate their patients' care. As a consequence, patients will no longer 'get the runaround', and primary-care providers will no longer be frustrated due to lack of communication, *ad hoc* approaches to referrals, and lack of common protocols, processes and goals between agencies. It seems that no one involved in Victoria's 32 newly formed PCPs is disputing this concept. (See the case study on page 22.)

Background

The concept was formulated under the Kennett Liberal Government, as PHACS: Primary Health and Community Support, which was a competitive strategy to reform primary-care services. Under the Bracks Labor Government, more emphasis has been placed on collaboration and integration among agencies. As a result of extensive lobbying from the health sector, the government dropped the ticklish issue of streamlining the funding; many

primary health-care service providers feared they would lose their autonomy as a result of any streamlining.

The Department of Human Services (DHS) document *Going Forward: A Primary Care Partnerships Strategy* became the new 'bible', and last year, PHACSs were transformed into PCPs, and formed alliances based on two or three local-government areas. Divisions of general practice actively participated in formation of these alliances; in fact, according to Dr John Stanton, who manages the DHS's General Practice and Integrated Care Unit, without the divisions, through which GPs have been given a collective voice, it would not have been possible to form the PCPs. However, at grass-roots level, the PCP concept is a bit like the theory of flight: a great idea, but a lot of work to get off the ground.

... without the divisions, through which GPs have been given a collective voice, it would not have been possible to form the PCPs.

Technological tussles

The key to effective co-ordination and integration of services is sharing of information about agencies,

Case study

WORKING AS PARTNERS: A FUTURE SCENARIO?

Jenk Akyalcin believes that ‘when we talk about the services directory, we should be talking about it in the context of practice – Initial Contact, Initial Needs Identification and Care Planning. The services directory should be seen as a tool to support practice.’ Mildura City Council’s ConnectingCare System <www.connectingcare.com> is an example of what might become possible using this sort of approach.*

A young woman presents at her local GP surgery. She has asthma, and is asking for some Ventolin. As part of the consultation, the GP undertakes an Initial Needs Identification – or, in GP terms, medical history, examination and diagnosis. A range of issues is thereby uncovered that affect the young woman’s health, such as the fact she has three children, including a baby who has colic, and that she has recently separated from her husband and has no social support.

The GP is not only able to organise a treatment plan for her patient’s asthma; she is able to use the online services directory to refer the patient to family-support and financial-assistance services. The directory contains not only up-to-date contact details and addresses for these services; it contains a list of the services, the eligibility criteria, the cost and the waiting times. The patient is thereby better able to understand what to expect, and is saved both time and money.

In future, with the patient’s consent, the GP will be able to share the patient’s information electronically with the other primary-care providers who will now be involved and to print a pamphlet about the services the patient has been referred to. She will be able to print and provide a copy of the *PCP Care Plan*, in which the patient is given the name and contact numbers for the person at the agency she has been referred to, the appointment time, the time for the follow-up appointment with the GP, and the GP’s contact details because the GP is the ongoing key contact.

The online services directory and referral system will be linked with the GP’s own clinical software, so the GP does not have to re-enter the information gathered through the Initial Needs Identification Tool and the Care Planning Tool.

The patient is better off, because she has not only had her asthma attended to; she is having other problems in her life that were affecting her health addressed. As well as support for her medical condition, she now has support for solving her social and financial problems.

The GP is better off, because she can easily access lots more information about the services available in her community, and can thereby both help her patient and help improve the patient’s care. She can also better understand her patient’s needs, and is not as isolated as she had been in her own job of caring for the patient.

The other primary-care providers in the PCP are also better off, because the referrals they receive contain information that is more relevant and precise; they are better able to understand the other issues in the patient’s life that might be affecting her health; and they have clearer paths of communication between themselves and the other people who are caring for the patient. In other words, the system works for the patient and the primary-care providers, not against them.

**Note that in this future scenario, it is assumed that many current issues have been successfully resolved – such as secure transfer of information, patient consent, confidentiality and compatibility of systems. For all health professionals in private practice, also illustrated is the need to agree about who is going to pay for the time involved in using the tools and transferring the information; until then, it is unlikely to be an expensive health professional who will be spending (unfunded) time using the INI.*

about their services and about the management of their patients.

If all this information is to be shared between the members of the 32 newly formed PCPs, the partners have to work out how they will process and store it – not to mention whether what they are doing in the first place works for both them and their patients.

When we consider the question of information management – IM – we are naturally led to consider the question of information technology – IT. Once the partners have sorted out the practices and processes that are involved, they have to consider what types of boxes and cables they will need, and how they will maintain the information's confidentiality, integrity and security while it is in transit.

At the time of writing, as the 30 June deadline for devising their Community Health Plans (CHPs) was looming, the partners in Victoria's 32 PCPs were forced to think about resolving all these issues. The writers of the plans identified the health priorities of the PCP's communities and described how the partners would work together to meet the priorities each year for the next three years.

Included in each plan is a three-year Information Management Strategic Plan, in which the writers identified the ways in which the partners would deliver their services to their patients. The projects for 2001–02 include, at the very least, setting up an electronic service directory and a co-ordinated approach to telecommunications. In the directory, all the information about the primary-care providers in the partnership will be incorporated. The information will be collected according to statewide data standards as identified by the DHS in consultation with the PCPs. Although the PCPs did not have to produce the service directory by 30 June, they had to show how they were going to produce it. The reason for the rush was that the plans were linked to the Budget cycle.

According to Paul Geyer, CEO of Central Bayside Division, because of the need to complete the plans, policy was turned into a 'nuts and bolts' activity. Unfortunately, the PCP partners were confused about how much technical information they had to include in the CHP, and the timeframe for implementing the plan was unrealistic. He states that although the health sector is 'incredibly information rich', it has 'an amazing lack of use of IT'. Some GPs are prescribing electronically, but DOS-based programs are still being used in other agencies, because 'they don't have the experience based in IT to make sound decisions'.

. . . because of the need to complete the plans, policy was turned into a 'nuts and bolts' activity.

Dr Peter Waxman is a former chair of Central Bayside Division, and agrees with Geyer: 'They're wanting a sophisticated IT proposal before the IM is sorted out.'

However, according to Jenk Akyalcin, the DHS's Information Management Industry Advisor, who is working directly with the PCPs, the deadline was as realistic as any other three-year business plan:

This CHP is an evolving document. We don't expect the detail to be absolutely signed off. It's an account of all the good work that has happened to date and the processes for moving forward . . . Yes, it puts pressure on PCPs, but we can't address the resources issue unless we have some notion of each PCP's requirements.

He believes that if the PCPs worked through the earlier processes as identified in the partnership-development plan, the CH Plan should simply be the next step.

Targeting the way GPs do things

Akyalcin states that he is trying to steer people away from viewing IT and IM as being:

a panacea for navigating through 'primary-care-provider land'. It's really about targeting practice: identifying the good practice in the primary-care setting, and bringing that practice to the surface so that other providers can be made aware of it, and compare it to their own and build on it.

By 'practice', he means both targeting GPs to get them involved and getting them to change the way they do things when that is in the consumer's interests:

The issue is persuading people to work together in different ways rather than being able to use the computer. This means that practitioners – GPs and other primary-care providers – have to be in a position to trust each other's work.

For an example, he cites the Initial Needs Identification (INI) process, through which a client enters the system, for example through the local community-health centre. The receptionist immediately links the client to the appropriate practitioner – say, an intake co-ordinator – for Initial Needs Identification; in other words, the intake co-ordinator assesses the patient's needs. The intake co-ordinator identifies a medical need for a GP's services. The intake co-ordinator shares

GP ENGAGEMENT

GPs who participate in a PCP are given the chance to overcome the isolation that traditionally characterises rural communities, and are able to be a part of a much more integrated health-care system.

However, it is difficult for all the partners to commit the time, energy and resources necessary for the PCP to be successful. Sometimes it's a 'catch 22' situation: in the long term, they stand to benefit, but in the short term, the gain does not justify the time they spend at meetings and the back-up resources they require.

According to some rural PCP partners, a two-hour meeting can be turned into a four-hour trip as a result of the distance involved. Under these circumstances, GPs have to weigh up the benefits both to themselves and to their patients.

This is where the Upper Hume PCP's Older Person's Tracking Project comes in. According to David Dart, executive officer of North East Victoria Division, 'It's quite a clever way of bringing GPs on board.' Based in Wodonga, the program is funded by the PCP and is conducted with Border Division. The PCP partners noticed that GPs were not very interested in taking up the case-conferencing and care-planning aspects of the Enhanced Primary Care MBS items, for which they had to work with other primary-care providers.

The PCP partners offered to set up a system in order to make this aspect easier for GPs, and at the same time to track a group of eligible people so any service gaps could be highlighted. They contracted Charles Sturt University to evaluate the findings, and two divisions of general practice (Border, and North East Victoria) to manage the project. The program

began in April this year, and 29 GPs have just begun recruiting about 70 patients to participate in it.

According to Leonard Peady, project officer with the Upper Hume PCP,

The tracking project attempts to learn about how our current health service is working for older people, where the gaps in service delivery are, and how we can improve systems to improve health outcomes. We'll be actively tracking and co-ordinating service delivery for people in the intervention group, but not for the control group.

The Hume Alliance of Rural Hospitals will prepare the IM and IT strategic plan, so the project will be the basis of the PCP's IMIT issues. To date, each PCP partner has had e-mail installed, but each one stores and transmits data differently. Peady states,

We don't have a system between all providers to transmit information, and no agreement to do that, and that will be one of the issues we're looking at.

He acknowledges that in the 12-month action-research project, 'a huge commitment for GPs' is required', but adds that the GPs have a strong stake in it: 'What's in it for GPs is that the system will be easier to work with.'

David Overton, executive officer at Border Division, acknowledges that:

GPs will need to modify systems in their practices to maximise the opportunities to be gained from working within the PCP. But there will also have to be changes made by the other partners and the DHS if they wish to gain the maximum benefits from GP participation.

the client's information with the GP, in ways that all the PCP partners have already discussed and agreed on. To accept the referral, the GP must be confident that the intake co-ordinator has asked the right questions; has sought the client's consent to share personal and health information; and is competent to judge the patient's risk, eligibility and priority for service.

According to Jenk Akyalcin,

That's what we mean by good practice. IT is just the boxes and cables, but IM is the process. If we don't

have the processes right, it doesn't matter how many boxes and cables we have: it's of limited value.

Dr John Stanton says that by 'practice', he means 'the way people work'; however, it means more than simply what they do: it means how they think about it:

It's that cultural shift -- for GPs to consider themselves part of a primary-care health network rather than isolated medical practitioners providing only medical care. If we haven't made that shift, all the service directories and electronic tools won't be much use.

New language

According to John Stanton, part of the problem that GPs have in accepting this is the language involved:

The whole concept of Initial Needs Identification is not a language that's used by GPs. GPs take a medical history, and do an examination and a diagnosis. These are the words that GPs would use, rather than 'Initial Needs Identification'.

He adds that terms such as 'Care Planning' and 'Case Conferencing' were also not part of a GP's vocabulary before November 1999, which was when the Enhanced Primary Care items were introduced.

Paul Geyer says that learning a new language to describe how things are done is not the only barrier to making PCPs work. According to him, some service providers are using patient confidentiality as a barrier to taking up IT:

And it's garbage, because if I e-mail something to you for a patient, it goes from my PC to your PC. A letter is opened by a receptionist, then sits in a file that anyone may open any time.

By comparison, in the case of software packages such as Cardinal, information is put on a secure Web site and access is protocol based, so that the various agencies are able to access only the parts that are relevant to them: 'You get this longitudinal health record over time; it's more comprehensive and not fragmented.'

Jenk Akyalcin believes that some agencies have 'some pretty damn good infrastructure'; however, how the GPs have been using the infrastructure is questionable, because organisations have not been addressing the IM or practice issues.

Kingston-Bayside PCP

A good example of effective infrastructure is Kingston-Bayside PCP's GP-HACC process of referral and feedback. The idea of having a common and more efficient referral system originated back in the days of PHACS, and was eventually funded by the Health and Community Care (HACC) Program, so that multiple points of referral were reduced to four. At first, the process involved faxing referrals and having the receiver fax back acknowledgement. More funding was then received to progress the process to electronic referral, known as e-ref.

According to Paul Geyer, in the project, a key problem that had been identified by primary-care providers and especially GPs was thereby addressed. However, 'Trouble is, it's never been used. No GP

transferred any information using e-ref -- maybe for one patient.'

The technology did not work properly, and the funding to fix it ran out.

Peter Waxman says that no resources were available to drive and maintain the change: 'People kept using the old forms.' A key problem was that GPs did not have as big a stake in its success as did community primary-care providers, for whom 90 per cent of business comes from referral.

E-ref also involved technical problems. Waxman was the only 'test site', and the cost of upgrading his software and adjusting his network was just too great: 'It took eight hours of consultant's time to get my systems working just to access PCP referrals, which are a very small proportion of my day.'

He is now considering using a Web-based solution:

The problem with this program is that we knew the result would be an IT end: it progressed to that before it was clarified. It jumped too far, without having supported the fax-back process.

It was a disappointing result, considering that having better access to services is a key element of the PCP strategy. Akyalcin views the situation as being 'a classic example of trying to manage change through technology rather than practice.'

Addressing practice

Akyalcin believes that the first step in addressing practice is to think about approaches through which a lot of providers can be engaged. He thinks that the best way to do this will be by piloting the tools that are being developed: the Initial Needs Identification Tool Template and the Care Planning Tool Template: 'They'll basically form the minimum-data set that forms the basis of a statewide referral platform; that's what GPs have been asking for for a long time.'

The Initial Needs Identification template will be like a screening tool through which all the patient's needs are captured, and not simply the clinical focus: 'It's also a tool that can be built on. That's why we can't have an IT system without thinking about these tools first.'

According to Akyalcin, the service directory is another good project, because it will meet the needs of a whole lot of players, including GPs. However, the processes will not always be IT based, and some service directories might even be a special section in the local 'white pages'.

The skills the partners will require

It is clear that the skills the PCP partners will require for the plan to be successful will be determined as a result of the model they develop and the way they want to do things. PCPs will have to think about what education and training they require in order to make best use of their model.

Some PCP partners might be considering setting up formal processes, such as links with local universities, whereas others might be considering setting up informal processes within their own organisation. However, at this stage, the main task is to persuade people to work together in different ways rather than be able to use the computer. Akyalcin states that providers need to know that other providers are competent, so they can trust the information they receive and confidence is built between the partners. In turn, according to Peter Waxman, respect is built – another vital element to making PCPs work:

You need to earn respect, and not all GPs and all service providers feel that others deserve respect. We're aiming to get to mutually respectful timely referrals and feedback. If we get to that point, we've got integration; if we don't do that, it's really referral, not communication.

However, he also states that someone has to pay for this: 'We have to convince GPs to have a managerial co-ordinating role, which requires resources.' He argues that the state should be the body that provides the resources through DHS.

According to Jenk Akyalcin, the IM money for the next financial year will be detailed as part of the project briefs: 'Beyond that, the plans will inform the department about the resources required.'

Conclusion

Jenk Akyalcin, Paul Geyer, Peter Waxman and John Stanton all agree that the challenge is to change the mindset, not just the practice, of everyone who is working in primary care, including GPs. PCPs must view IM and IT as being a vehicle for change, not change itself. As well as the demands inherent in the plans, much work has to be done on the way the information is gathered and shared, as well as on building relationships between agencies, before PCP partners can decide how to transmit or store the information.

According to John Stanton, the shift from writing on prescription pads to preparing computer-generated prescriptions is an interesting parallel:

Doctors have been writing patients' scripts for hundreds of years, but until a few years ago, these

were handwritten. There's been a dramatic shift towards GPs' going to computer-generated scripts. I guess they shifted because they saw it as a useful tool.

He believes that if the PCP partners view the service directory and other tools in the same way, the same shift will occur.

. . . the technology should have a supporting role, not the starring role, in the PCP show.

For the PCP partners, before they decide which tools they are going to use, the issue now is to work out what they want to achieve and how they are going to work together to achieve it. Akyalcin states that the technology should have a supporting role, not the starring role, in the PCP show. It does not matter whether the PCP partners use IT, a paper-based system or carrier pigeons, as long as their choices support the way the partners do things.

Jane Cafarella is a Melbourne-based journalist who regularly writes feature articles for journals and newspapers such as *The Age*.

Addiction medicine and the busy GP: time for a change

Benny Monheit

In Victoria, GPs have been providing drug-dependent people with most of the state's methadone programs and medical treatments. Demands on these GPs will inevitably increase, so different ways of providing and funding this ongoing community service will have to be found within the state medical system.



Among Australia's community-based drug and alcohol treatment programs, Victoria has been setting the pace. The state's GPs have been providing most of the medical services for drug-dependent patients participating in a methadone program or attending a drug-withdrawal unit, and have also been advising and supporting many of the families affected by the addiction. Now, however, it seems a ceiling has been reached: because the heroin epidemic is spreading and the workload from other areas of general practice is increasing, many GPs are reluctant to become involved in treating addicts.

According to data released by the Department of Human Services, only 6 per cent of Victorian GPs prescribe methadone for the 7500 patients enrolled in the methadone program. Of these prescribers, 20 per cent treat 70 per cent of the patients. Recruitment of new prescribers is a slow process and is unable to meet the demand for prescribers, which is increasing at an annual rate of 15 per cent. Doctors are similarly scarce and difficult to recruit for the drug-withdrawal units, in which patients undergo detoxification and medication in a five- to seven-day live-in program.

... only 6 per cent of Victorian GPs prescribe methadone for the 7500 patients enrolled in the methadone program.

'Penington' review recommendations

Recently, these problems have been recognised by the members of the Drug Policy Expert Committee, who compiled the 'Penington' review and included the following two recommendations to the Bracks State Government.

That the government work with the Commonwealth Government and Divisions of General Practice to enhance the effectiveness of general practitioners in interventions in drug-related issues, and their willingness to participate in the pharmacotherapy service.

That the Government undertake a systematic review of prescriber and dispenser arrangements with each General Practice Division.

What doctors need

At the Drug Policy launch, held on 28 November 2000, the State Government accepted these broad recommendations. However, over the ensuing five months, not much happened. Then, at the end of April this year, the State Health Department indicated it was considering the options. It invited three methadone prescribers and one representative of the broader GP movement to participate in a brainstorming session, which was also attended by researchers and department representatives. At that meeting, the doctors pointed out to the department representatives that in Victoria, major obstacles to increasing the number of treatment places are the result of negative community and medical-peer attitudes as well as lack of support for the GPs working in the drug and alcohol rehabilitation area. Although financial issues are part of the problem, they are not necessarily the dominant issue. According to the doctors, for GPs to be willing to see and treat more drug users, they require:

- better access to social workers and case workers in order to deal with the myriad social problems experienced by some of the doctors' patients
- rapid access to the Specialist Methadone Service clinics for the doctors' difficult and complex patients
- support for GP-oriented training and advice
- support for the doctors' infrastructure, especially secretarial support, so the doctors can deal with the extra administrative work, imposed by the State Government, for processing pharmacotherapy permits; arranging program transfers; and liaising with people who work in drug and alcohol rehabilitation, such as pharmacists, hospital staff members and child-protection workers.

... negative community and medical-peer attitudes as well as lack of support for the GPs working in the drug and alcohol rehabilitation area.

Financial incentives

At the brainstorming session, the participants spent quite some time discussing the idea of introducing financial incentives for doctors to become more involved in drug and alcohol rehabilitation. However, they did not reach any clear consensus as to whether it was more important to introduce the incentives for new doctors as opposed to doctors who already have an interest in the area.

Divisions' role unclear

The doctors also discussed, with the department representatives, the role of divisions of general practice in the addiction-medicine area. It seemed to the doctors that the staff members of the department's Public Health Division have not understood the role or scope of divisions, which have, of course, been set up, nurtured and funded by the Commonwealth Government. It remained unclear how the State Government would implement the Drug Policy Expert Committee's recommendations with reference to how divisions would be involved in implementing the changes.

Community clinics

However, the participants widely supported the idea that new treatment models should be explored in order to build on and enhance Victoria's community-based program for treating drug and alcohol addiction. In particular, they accepted that the best way to meet GPs' need for extra support was to develop new methadone services within existing drug and alcohol agencies or community-health settings. They cited several successful examples of this strategy, including the ones located in the cities of Geelong and Bendigo, in which GPs have collaborated to provide very popular methadone programs based at mental-health clinics or community-health centres. The State Government has been able to provide some funding for secretarial and counselling support, and during holidays and at other times of need, the GPs are able to have one of their colleagues cover for them.

... GPs have collaborated to provide very popular methadone programs based at mental-health clinics or community-health centres.

If this community-clinic model is expanded, and GPs and local resources are used in it, more GPs could be encouraged to work in a community clinic for one or two sessions per week and thereby

Divisions providing program activities

Over the past year, 15 of Victoria's divisions -- about half the total number -- have been providing program activities for people undergoing rehabilitation for addiction to alcohol or another drug. The 15 divisions are listed below. The GP members of nine of the 15 divisions focused on educating the GPs about prescribing methadone for their heroin-addicted patients; dealing with their patients who abuse a substance or have an addictive disorder; referring their patients appropriately; and minimising harm to their patients.

In many of the division programs, the GPs have been working with specialist drug and alcohol services as well as other agencies. Three specific examples are:

- the GP Methadone Mentor Scheme, in which the GPs and members of the regional Drug and Alcohol Service have adopted a shared-care approach to managing heroin addiction (Westgate and Western Melbourne)
- the GPs' participation in development of a drug and alcohol withdrawal program for members of the Indo-Chinese community (Monash)
- the GPs' case conferencing with allied health professionals and the St Vincent's Drug and Alcohol Consultancy Service (Goulburn Valley).

The 15 participating divisions

Ballarat, Bendigo, Central Highlands, Goulburn Valley, Greater South East, Inner Eastern Melbourne, Knox, Melbourne, Monash, Murray Plains, North East Victoria, Sherbrooke and Pakenham, Southcity GP Services, Western Melbourne, and Westgate

provide addicted patients with a much needed high-standard, affordable and efficient drug-treatment program.

A special-interest area

Some Victorian divisions have taken on a leadership or support role for GPs working in the drug-rehabilitation area, and for these doctors the area has become a special-interest one, in the same way as have women's health and sports medicine.



Divisions can definitely have a vital role in facilitating development of the next phase of Victoria's unique community methadone program. However, for this to occur, the State Government has to better appreciate, fund and support the role of GPs.

Benny Monheit is a general practitioner at Vaucluse Private Consulting Rooms, located in Brunswick, an ethnically diverse inner northern suburb of Melbourne. He is also director of the Southern Metropolitan Addiction Consultancy Clinic, which is auspiced and managed by Southcity GP Services, the division that covers the area based on Prahran, St Kilda, South Melbourne and Caulfield.

Acronyms and abbreviations used in this issue

ADGP	Australian Divisions of General Practice
AMA	Australian Medical Association
ADSL	high-speed use of analog phone lines (Asymmetric Digital Subscriber Line)
CHP	Community Health Plan
DHAC/DH&AC	Department of Health and Aged Care (Commonwealth)
DHS	Department of Human Services (Victoria)
DOS	Disk Operating System
GPCG	General Practice Computing Group
GPPAC	General Practice Partnership Advisory Council
HACC	Health and Community Care
HCN	Health Computing Network
HIC	Health Insurance Commission
ICP	Integrated Care Program
IM	information management
IMIT	information management and information technology
INI	Initial Needs Identification
ISP	Internet service provider
ISDN	high-speed phone lines (Integrated Services Digital Network)
IT	information technology
LCD	liquid-crystal display
MSIA	Medical Software Industry Association
MYOB	Australian accounting software (Mind Your Own Business)
PCP	Primary Care Partnership
PHACS	Primary Health and Community Support
PIP	Practice Incentives Program
RACGP	Royal Australian College of General Practitioners
RDA	Rural Doctors' Association of Australia
SBO	state-based organisation
STD	Subscriber Trunk Dialling
UPS	uninterruptible power supply

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In each issue, one theme is treated in detail, but future issues will include articles about other matters that are unrelated to the chosen theme.

We encourage you to contribute articles and letters.

The themes for the next two issues are:

Structural change in general practice

September 2001

GPs, divisions and pharmacy

December 2001

QUARTERLY
DIVISIONS

We value your feedback

As we approach our seventh issue, we are conducting an independent review of the journal's content and purposes. We are formally approaching divisions and selected individuals, but encourage all readers to send comments for consideration by the review team.

If you have positive feedback, suggestions for improvement or change, or any other feedback, please send your comments to Vanessa Collinson at:

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